STATE OF MICHIGAN

DEPARTMENT OF CONSUMER & INDUSTRY SERVICES

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXXXXXXXXX

Petitioner, **File No. 54137-001**

v.

Blue Cross and Blue Shield of Michigan

Respondent.

_____/

Issued and entered
this 10th day of July 2003
by Linda A. Watters
Commissioner

ORDER

PROCEDURAL BACKGROUND

On May 19, 2003, XXXXXXXXXXXXXX, on behalf of XXXXXXXXXX filed a request for external review with the Commissioner of Financial and Insurance Services (Commissioner) under the Patient's Right to Independent Review Act (PRIRA) MCL 550.1901 *et seq.* After a review of the material submitted, the Commissioner accepted the request on May 27, 2003.

The issue involved in the adverse determination is contractual. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). As a result, review by an independent review organization is not required. The Commissioner

notified Blue Cross and Blue Shield of Michigan (BCBSM) of this filing and requested the information it used in making its adverse determination. The Office of Financial and Insurance Services received information from BCBSM on June 2, 2003.

II
FACTUAL BACKGROUND

On XXXXXXXXXX, the Petitioner had surgery at XXXXXXXXXXXXX for a herniated disc. The neurosurgeon from XXXXXXXXXXXXXXXXXXXXXXX does not participate with BCBSM. The Petitioner was billed the balance after BCBSM paid the approved amount. The cost breakdown for the date of service is as follows:

Procedure Code	Amt. Charged	Amt. Paid	Subscriber's Balance
63030	$3,700	$1,098.19	$2,601.81
69990	$1,000	$258.63	$741.37
76000	$120	$10.54	$109.46

Petitioner grieved the amount paid by BCBSM. A Managerial-Level Conference was conducted on XXXXXXXX. Additional payment was not approved. The Petitioner was notified of the final adverse determination on April 21, 2003.

III
ISSUE

Did Blue Cross and Blue Shield of Michigan (BCBSM) pay the correct amount for the Petitioner's surgery?

IV
ANALYSIS

Petitioner's Argument

Petitioner had back surgery on XXXXXXXXX, for a herniated disc. Blue Cross paid $1,367.36 of the $4,820.00 total bill. Petitioner believes BCBSM did not pay enough for necessary medical services according to the contract. XXXXXXX

XXXXXXXXXXXXXXXXXXXXis one of the only providers of this service in the XXXXX area. The amount paid by BCBSM is inadequate compared to what other insurance companies approve and pay. It is unreasonable to go out of the area, like to XXXXXXXXX, which would likely involve an overnight stay instead of outpatient surgery.

BCBSM's Argument

Petitioner has health coverage under BCBSM's Community Blue Group Benefit Certificate (Certificate) as amended by the Rider RAPS (Reimbursement Arrangement for Professional Services). Under the Certificate, participating doctors agree to accept BCBSM's approved amount as payment in full for a covered service. A participating doctor cannot charge the patient the remaining balance even if the BCBSM payment is lower than the amount the doctor normally charges. If the member selects a non-participating doctor, BCBSM will pay the same approved amount it pays to a participating doctor. The non-participating doctor, however, is not bound to accept the BCBSM amount as payment in full. The doctor may bill the patient for the balance.

BCBSM determines the payment level for each service by applying a Resource Based Relative Value Scale (RBRVS). RBRVS reflects the resources required to perform each service. It includes physician time, specialty training, malpractice premiums, practice expenses and overhead. BCBSM regularly reviews the payment level to address the effects of changing technology, training, and medical practice.

The $1,367.36 paid for the surgery is the maximum approved amount for the procedures. This payment complies with the Certificate's payment provisions. In addition, there is no provision in the Certificate or Rider to pay more than the maximum payment level. BCBSM claims that numerous participating surgeons are within a reasonable distance from Petitioner's home, including XXXXXXX and XXXXXXXX (approximately 40 miles) and XXXXXXXXX (approximately 60 miles).

Commissioner's Review

The Certificate of Coverage controls the analysis in this matter. A non-participating provider is defined as:

> Physicians, or other health care professionals or facilities that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. However, nonparticipating providers may agree to accept the approved amount on a per claim basis.

This language places a subscriber on notice that BCBSM pays an "approved amount" and that a non-participating physician is not bound to accept the amount as payment in full.

Moreover, Section 2 of the RAPS Rider informs a subscriber that he or she may be affected when a non-participating provider is used. It states:

> When you receive services from a non-participating provider, you should expect to pay charges to a non-participating provider at the time you receive the care. It is then your responsibility to submit a claim to us. If we approve the claim, we will send the payment directly to you. **Because non-participating providers may charge more than our approved amount**, ***our payment to you may be less than the amount charged by the provider…*** [Emphasis added]

The rider puts subscribers on notice that if they obtain services from non-participating providers, they may incur personal liability for charges that exceed BCBSM's maximum payment level. According to the rider, BCBSM pays either the charge for a covered service or BCBSM's maximum payment level for the covered service, depending on which is less. BCBSM does not require a subscriber to go to a participating provider but to limit personal liability a subscriber must go to a participating provider.

The provision to pay an approved amount may be invalid if no participating providers were available within a reasonable distance. However, BCBSM indicates

there are participating physicians within a reasonable distance from Petitioner's home. Petitioner, on the contrary did not produce evidence that participating physicians were not available. It is the subscriber's responsibility to determine whether a physician participates with BCBSM. In this case, the surgeon is a non-participating provider with BCBSM. He does not have to accept the approved amount and is free to charge a reasonable and competitive amount.

The Commissioner empathizes with the Petitioner, but it is clear that the Petitioner is responsible for the balance of the charges. The Commissioner finds the amount paid by BCBSM is consistent with its system of payments.

V
ORDER

The Commissioner upholds the BCBSM final adverse determination. BCBSM is not required to pay an additional amount for Petitioner's XXXXXXXXXXXXXXX, surgical services.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this order may seek judicial review no later than sixty days from the date of this order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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Linda A. Watters
Commissioner